

Cincinnati Children's Hospital Medical Center

Division of Occupational Therapy and Physical Therapy

Individualized Needs Assessment

Thank you for choosing Cincinnati Children's. Please complete this questionnaire so we can become more familiar with your child. This information will help us determine how we can be most helpful to you and your child. Please see the receptionist if you need special assistance during your visit. Thank You!

Child's full name: _____ Child's birthdate: _____

Name of person completing this form: _____

Relationship to child: _____

Information About Your Child

Parent/Caregiver Concerns

Please describe what your child does well: _____

Please describe what your child has difficulty with that you would like us to check today: _____

Does your child have pain that you would like us to check today? No Yes If yes, please describe: _____

Relevant Medical Information

1. Physicians currently involved in your child's care: _____

2. Current diagnoses/infections (please list): _____

3. Recent hospitalizations: No Yes If yes, please describe: _____

4. Recent surgery: No Yes If yes, please describe: _____

5. Diagnostic tests: Bone scan MRI CAT scan Upper GI Swallow study X-rays _____

Results: _____

6. Medications your child currently takes: _____

7. Special equipment your child uses: Splint Braces Walker Crutches Wheelchair Other _____

8. Previous psychological testing: No Yes Results of testing indicate (check all that apply):

Learning Disability Attention Deficit Disorder Hyperactivity Mental Retardation

Developmental Delay Autism/Pervasive Developmental Disorder Behavioral Disturbance

Depression Needs Special Education Services Other _____

9. Please check all that apply to your child:

Seizures G-tube Food allergies Wears hearing aids Wears glasses

C-Line Latex sensitivity Hearing difficulty Vision problem

Information About the Family

Cultural and Spiritual Needs

Are there any cultural or religious preferences you would like us to consider when delivering treatment?

No Yes If yes, please explain: _____

Family Educational Needs

Preferred language: Child _____ Preferred language: Parent/Guardian _____

Best way to teach child: Verbal instructions Demonstration Written instructions

Best way to teach parent/caregiver: Verbal instructions Demonstration Written instructions

Does child's parent/caregiver have physical limitations, visual or hearing deficits, learning difficulties or other

special needs? No Yes If yes, please describe: _____

If you have concerns regarding your child's growth and development, that you wish to have addressed today, please complete back page.

Please complete this page only if you have concerns regarding your child's growth and development that you wish to have checked today.

Birth History

Child was born: ____ Full term or ____ Weeks premature

Child's delivery was ____ Vaginal ____ With forceps ____ Cesarean

Describe any problems during labor and delivery: _____

Birth weight: ____ Was oxygen required? ____ No ____ Yes If yes, how long? _____

Was child in the Newborn Intensive Care Unit? ____ No ____ Yes If yes, how long? _____

Medical problems at birth: _____

Physical Development

Please indicate at what age your child achieved the following developmental milestones:

(Mark N/A if your child has not yet attained a particular skill)

Rolled over _____ Walked holding onto furniture _____ Drank from cup alone _____

Sat alone _____ Stood alone _____ Toilet trained _____

Crawled on hands and knees _____ Walked alone _____ Dressed self _____

Pulled to stand _____ Used spoon _____ Used crayon to color _____

Describe any early and/or current feeding problems or nutritional concerns: _____

Additional Comments: _____

School and Therapy Services

School/program currently attending: _____ Present grade: _____

Special services received in school: ____ OT ____ PT ____ Speech therapy ____ Resource services

Special education ____ Behavior intervention ____ Other special services _____

Does your child's teacher have concerns about your child's development in any of these areas:

____ Motor skills ____ Social abilities ____ Self-help skills ____ Cognitive skills/learning abilities

Additional comments: _____

Behavioral and Emotional Development

Check the box that best describes your child's behavior.

Always: Responds 100% of the time this way

Frequently: Responds 75% of the time this way

Occasionally: Responds 50% of the time this way

Seldom: Responds 25% of the time this way

Never: 0%

	Always	Frequently	Occasionally	Seldom	Never
Is distracted or has trouble functioning if there is a lot of noise around					
Has difficulty putting puzzles together (as compared to same age children)					
Avoids playground equipment or moving toys (for example, swing set, merry-go-round)					
Twirls/spins self frequently throughout the day (for example, likes dizzy feeling)					
Reacts emotionally or aggressively to touch					
Has difficulty paying attention					
Will only eat certain tastes (list _____)					
Picky eater, especially regarding food textures					
Poor endurance/tires easily					
Seems accident prone					
Avoids eye contact					
Seems anxious					
Is stubborn or uncooperative					
Cries easily					
Has difficulty making friends (for example, does not interact or participate in group play)					
Writing is illegible					
Has difficulty tolerating changes in routine					
Has difficulty following directions					